wp|property|finance
Finance Made Easy

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Financial Services and Markets Act 2000

Independent Financial Advisers and mortgage brokers are required to have proper regard for a client's best interests in any advice given. They must therefore do their utmost to ensure that they are aware of your financial circumstances so that their advice is the most suitable for your needs. The questions here have been specifically designed to help your adviser provide advice that meets your needs. If, for any reason, you decline to answer any, or all the questions or, if you fail to provide true and accurate information to the best of your knowledge, the advice given subsequently may not be best advice, as it can only be based on the information provided in this document.

Protection Data Capture Form

Date completed:

All applicants should complete the form thoroughly and answer all questions. If you answer yes to any question please provide all details and dates where relevant.

Failure to disclose relevant information could result in the non-payment of a claim.

Existing Cover:

	Applicant 1:	Applicant 2:
Please provide details of existing cover:		
If any applicant has ever had an application for life, critical illness, or income protection cover which has been turned down or accepted on special terms, e.g. an increased premium or exclusion, provide name of the provider, date and details of the decision:		

Budget:

Please provide an amount for your affordable monthly budget

Applicant 1:

Applicant 2:

Pastimes:

	Applicant 1:	Applicant 2:
If you intend to take part in any potentially dangerous or hazardous sports or activities such as mountaineering, diving, private flying, motor etc. please provide details and regularity		

Lifestyle questions:

	Applicant 1:	Applicant 2:
Your height: ft. ins / cm.		
Your weight: st. lbs / kilos		
Waist/dress size: ins. / cm.		
If you a smoker of have you used nicotine products or e-cigarettes please provide details i.e. number of cigarettes/cigars per day, pipe smoker amount, or other nicotine usage: ***Random test may be carried out to verify smoking status***		

How many units of alcohol do you drink per week?		

1 pint of beer = 3 units of alcohol. 1 glass of wine = 1.5 units of alcohol. 1 measure of spirits = 1 unit of alcohol.

If you have been advised by your doctor or other medical practitioner to drink less alcohol please provide details and dates of your consultations		
If you have ever taken any recreational drugs, e.g. cannabis, ecstasy, heroin, cocaine, or any prescription drugs not prescribed by your doctor, please provide details and dates of the events:		
If, during the last 5 years you have lived or travelled abroad, other than for holidays for up to 30 days per year, please provide details and dates of the countries visited and duration of your stay:		

Do you intend to travel or work outside the UK?	yes	☐	no	☐	yes	☐	no	☐

Doctors details:

Please provide the name or your GP or Practice. Please note we may not necessarily contact your doctor but even if we do, we still need you disclose all material facts of your medical history. If you have been registered with your current GP or Practice for less than 6 months, please provide previous doctors details in the notes section

	Applicant 1:	Applicant 2:
Doctor or practice name:		
How long registered with them:		
Full address of GP or Practice:		
Telephone number:		

Main medical summary:

If you answer 'yes' to any question, please give full details, i.e. symptoms or diagnosis of condition, dates and duration, who was consulted, details and results of any tests and whether or not a full recovery was made. Please note that for those conditions indicated with an asterisk additional questions will be required. Please do not assume that we will contact your doctor and that your doctor will provide the information we need. It remains your responsibility to complete this application form fully.

Do you have, or have you ever had any of the following? if yes, tick the box and provide an explanation :	Applicant 1:	Applicant 2:
Any form of cancer, leukaemia, Hodgkin's disease, spinal tumour, lymphoma or melanoma?	☐	☐
Heart disorder including heart attack, angina, cardiomyopathy or heart murmur?	☐	☐
Stroke, brain haemorrhage, transient ischaemic attack (TIA), brain injury or brain tumour?	☐	☐
Multiple sclerosis, Parkinson's disease, paralysis, Alzheimer's disease, dementia or cerebral palsy?	☐	☐
Numbness, loss of feeling, tingling, tremor or temporary loss of muscle power?	☐	☐

Blindness, blurred or disturbed vision not fully corrected by glasses or contact lenses, e.g. optic neuritis or glaucoma? ☐ ☐

Diabetes or sugar in the urine?* ☐ ☐

Mental illness that has required hospital treatment or referral to a psychiatrist?* ☐ ☐

Medical history:

In the last 5 years, have you had any of the following?, if yes, tick the box and provide an explanation. Applicant 1: Applicant 2

A lump or growth of any kind; or any mole or freckle that has bled, become painful, changed colour or increased in size?* ☐ ☐

Chest pain, irregular heartbeat, raised blood pressure or raised cholesterol? ☐ ☐

Asthma?* ☐ ☐

Breathlessness, bronchitis, sarcoidosis or any lung disease other than asthma?* ☐ ☐

Epilepsy, dizziness or blackouts?* ☐ ☐

Deafness or any ear problem?* ☐ ☐

Arthritis, or any muscle, bone or joint disorder (e.g. sciatica, back, neck, shoulder or knee pain, RSI or gout?)* ☐ ☐

Disorder of the digestive system, liver, stomach, pancreas or bowel including ulcers, hepatitis, colitis or Crohn's disease?* ☐ ☐

Blood disorder or anaemia? ☐ ☐

Thyroid disorder?* ☐ ☐

Any kidney, bladder or other genito-urinary disorder, including blood or protein in the urine, kidney cysts or multiple urinary tract infections?* ☐ ☐

Stress, anxiety, depression, insomnia, chronic fatigue or any psychiatric or eating disorder?* ☐ ☐

Any skin disorder or allergy?* ☐ ☐

(Females only) Abnormal cervical smear or mammogram, or had a biopsy of the breast cervix or uterus?* ☐ ☐

(Males only) Prostate enlargement or raised PSA (prostate specific antigen)? ☐ ☐

Medical history – other:

In the last five years, other than for the medical conditions already mentioned, have you… Applicant 1: Applicant 2:

Had or have been advised to have any medical investigations, scans or blood tests? ☐ ☐

Received any form of medical attention at a hospital as an in-patient or out-patient? ☐ ☐

General Health Questions:

Are you currently experiencing any symptoms or disorder for which you have not consulted a doctor? ☐ ☐

Are you currently taking any drugs, medicines or tablets or receiving any other treatment for a condition not already mentioned? ☐ ☐

Are you currently awaiting a medical consultation or hospital appointment, or awaiting the results of any tests? ☐ ☐

Have you ever tested positive for HIV, hepatitis B or C or are you awaiting the results of a test? ☐ ☐

(If the result of negative, the fact that you have had an HIV test will not affect your application for insurance

Within the last five years have you been exposed to the risk of HIV infection? ☐ ☐

This can be through unsafe sex, intravenous drug use or blood transfusions or surgery outside the EU.

Within the last five years have you tested positive or been treated for any disease which was transmitted sexually? ☐ ☐

Have you had more than 15 days sick leave in the last two years? ☐ ☐

Covid-19 Questions:

Have you had a positive Covid-19 test? and if so, please provide the date: ☐ ☐

Have you been asked to self-isolate? ☐ ☐

Have you been in contact with someone who has had, or does have Covid-19 ☐ ☐

Family History:

Have any of your parents, brother or sisters ever had any of the following medical conditions before they reached the age of 60?

If you are unable to answer this section due to being adopted or similar circumstances, please indicate in the notes below and explain the reasons why you are unable to answer in the space(s) below.

Alzheimer's disease ☐ ☐

cancer ☐ ☐

Diabetes ☐ ☐

haemochromatosis ☐ ☐

Heart Disease (including cardiomyopathy, heart attack or angina)	☐	☐
Huntington's disease	☐	☐
Kidney failure or polycystic kidney disease	☐	☐
Motor neurone disease	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Polyposis of the colon	☐	☐
Stroke	☐	☐
Any hereditary disorder	☐	☐

Notes: Reasons why you unable to answer the above or any additional information you feel is relevant:

Further Medical Information:

Please use this section to provide any further relevant information in relation to any question/s asked in this form.